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BRICS' role in global health and the promotion of universal health coverage: the debate continues

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Introduction

The acronym BRIC was coined in 2001 by Jim O'Neill, a senior executive at Goldman Sachs, to denote four emerging national economies: Brazil, the Russian Federation, India and China.¹ The acronym was subsequently extended – to BRICS – to include South Africa. Together, the nations in the BRICS group, which are widely considered to represent the most important emerging economies, hold approximately 40% of the world's population. Although BRICS and other multinational groupings may be useful to policy-makers involved in the development of some foreign policies, it remains unclear if such groupings have a role in the study and development of global health policy. We examine the debate around this issue and focus on the potential role of BRICS in the promotion of universal health coverage – an “umbrella” goal for health in the post-2015 development framework.²

The debate

There are those who see a strong potential role for BRICS in the development of universal health coverage. These people observe how Brazil, China, India and South Africa have all made considerable recent progress in expanding health coverage. Such success has inspired other governments. In addition, BRICS are committed to spreading the lessons they have learned from their recent experiences. By offering diplomatic support and acting as technical resources, these nations are also increasingly promoting the development of various global health policies – including universal health coverage. For example, in 2012, at

the Sixty-fifth World Health Assembly, representatives of the BRICS countries “stressed the importance of universal health coverage as an essential instrument for the achievement of the right to health”.¹ In a communiqué issued at a health ministerial meeting in 2013, the same nations declared their support for the then recent United Nations resolution on universal health coverage and stated that they were “committed to work nationally, regionally and globally to ensure that universal health coverage is achieved”. Subsequently – at the Sixty-sixth World Health Assembly – the BRICS countries agreed to identify national institutions that could collaborate with the World Health Organization (WHO) in developing a monitoring framework that would help track progress towards universal health coverage.

Since the BRICS grouping was based on national economies, it sometimes appears awkward and artificial in the health policy arena. The BRICS countries vary greatly in terms of their burdens of disease, health systems, interests in the global pharmaceutical trade, engagement in the international arena and much else.³ While the health ministers of these five nations have met – and continue to meet and share concerns – on a regular basis, the resultant declarations and communiqués appear to have had little real impact on any global health policy. There are several reasons for BRICS' increasing prominence in the global health discourse despite this lack of impact. The emergence of BRICS as a distinct entity with increasing levels of multinational coordination in health – and other – activities is applying pressure to both the existing and emerging mechanisms and processes

of global governance. Many of those who promote universal health coverage, whether as researchers, politicians or advisors, often seem to be searching for leadership and inspiration from national governments and regional or other blocs. Some nations that once provided such leadership have largely withdrawn and this has left a gap that BRICS could conceivably fill. More research is needed to explore whether this gap really exists, whether or not it matters, and whether it could really be filled by BRICS. The former Soviet Union, which paraded its achievements in implementing universal health coverage at Alma-Ata in 1978, has ceased to exist. The Non-Aligned Movement, which shaped many global health debates in the 1970s and 1980s, has largely disappeared from the stage.⁴ Given its long struggle to implement universal health coverage at home, the United States of America appears to be poorly placed to promote such coverage elsewhere. The European Union often finds itself paralyzed, with its member states unable to agree on a common position. While many might be looking to BRICS for leadership, it is still not clear if these countries have sufficient shared interests or the coordinating mechanisms and processes needed to collectively and cohesively influence or promote global health policy.³

In the global arena, Brazil – especially under ex-President Lula da Silva – has promoted universal health coverage and, especially, action on the social determinants of health. Although the former Soviet Union achieved universal coverage, the Russian Federation has said relatively little about such coverage in recent years. India and South Africa have both committed themselves to

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seeking universal health coverage and have promoted such coverage nationally. China appears to be primarily focused on domestic reform but hosted a recent ministerial forum on China–Africa health development and has committed itself to working with African countries to support efforts towards universal health coverage.^{5,6} Although the positions and policies on global health of some of the BRICS countries are congruent, they are not always aligned and often appear far from coordinated.

Discussion

Among those seeking to promote universal health coverage, there is a natural desire to look not only to WHO, the World Bank, the Rockefeller Foundation and other “global” institutions, but also to nations that can champion this cause – rather than to leave the agenda to be driven by corporate interests. The BRICS countries may currently appear to be attractive promoters of universal health coverage but they do not yet – and may never – work collectively to fulfil this role. They are

certainly not the only countries seeking to influence the ongoing discussions on global health policy. Cuba, Mexico, Thailand and Turkey, for example, have been seeking to shape such discussions and so boost their “soft power” in the global arena. In the industrialized world, Germany, Japan, Norway and Sweden have also been joining in this process but – with the exception of the Oslo grouping⁷ – there is little evidence of any multinational coordination to increase the impact of such nations in the global health arena.

The group of countries that can act – and is willing to act – as exemplars for others in the development of universal health coverage is not, however, “set in stone”. Twenty-five years ago, a list of influential countries might have included Costa Rica and Sri Lanka – now largely absent from the debate.⁸ In the near future, countries such as Chile and Rwanda may make substantial gains in their global influence. Those looking for champions in global health – particularly in the fevered fight to establish the post-2015 development agenda – may be currently looking in the wrong place.

Conclusion

We do not argue that BRICS has no value as a grouping. These five countries do have some things in common: they are all large, populous, and diverse and have many different ethnic, social and – in some cases – religious divisions. They share these characteristics with some other countries – e.g. Indonesia, Nigeria and Pakistan – that have made less progress towards universal health coverage but may be able to learn from BRICS’ experiences. There is no doubt that, in the promotion of universal health coverage, collaboration and shared learning are required. However, a grouping of countries that makes sense in the coordination of global macroeconomic policy cannot be assumed to be relevant in the development of any global health policy. ■

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